



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

Carrier's Austin Representative Box

Box Number 47

Respondent Name

TRANSPORTATION INSURANCE CO

MDR Received Date

February 2, 2012

MFDR Tracking Number

M4-12-1902-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Texas State appointed doctor evaluated me as having 25% Impairment Rating. His conclusions agreed with other specialists & surgeons. That is: my injuries are the results of my w/c injuries. YET – CNA has not paid my doctors, hospital labs, surgeons, Rx's nor reimbursed me for any of my Rx's, doctor bills, daily medicines, mileage, & other medical bills in years until I received CNA check in my Saturday afternoon mail on Nov. 12, 2011 covering 3 out of my 57 requests for reimbursement of part of medicines. I live in Tx. – so – I did not receive my retirement. CAN took me thru many BRC meetings, 3 Contested Case Hearings & to Appeal Panel of Tx. 3 different year's – and – TWCC always ruled in my favor."

Amount in Dispute: \$122.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As explained in the DWC62 and attachments (Exhibit H), the \$90.42 request for reimbursement was denied because no medical records were attached and to this date still have not been received. The \$31.94 was denied as reflected on the Form OMB-14 in Exhibit H as "Duplicate paid prior". After inspection of the Wal-mart receipts included with both Exhibit A (Claimant's original request for reimbursement) and Exhibit F (the subsequent request), it is clear that the claimant has mistakenly submitted the same reimbursement request for the disputed prescription reimbursement. The original submission (Exhibit A) resulted in reimbursement for the Colace x 2 as part of the \$519.16 payment to Claimant."

Response Submitted by: Law Offices of Grian J. Judis, 600 N. Pearl, Ste. 1450, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
Janury 20, 2011	Out-of-Pocket Expenses for Medical Treatment – CPT Code 95165	\$30.14	\$0.00
February 16, 2011 March 24, 2011	Out-of-Pocket Expenses for Medical Treatment – CPT Code 95165	\$60.28	\$60.28
December 2, 2011	Out-of-Pocket Expenses for Prescription Medication – Colace	\$31.94	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured employees to recoup out-of-pocket expenses related to their work related injury.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated January 11, 2012 contained no denial codes. The reason for reduction/denial was: "medical/office notes required bill/HCF1500 bill from the medical provider – cannot process balance due after Medicare has paid portion."

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Did the injured worker adhere to the procedures set out in 28 Texas Administrative Code §133.270, related to the reimbursement for out of pocket expenses incurred by the injured employee?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307(c)(1)(A) date of service January 10, 2011 was not received at the Division within one year from the date of service; therefore, this date is not eligible for review. Dates of service February 16, 2011 and March 24, 2011 were submitted timely and will be reviewed in accordance with Division Rules and Statutes.
2. In accordance with 28 Texas Administrative Code §133.270 the requestor submitted receipts showing payment was made by the injured worker for medical treatment of the compensable injury to the insurance carrier. Review of the insurance carrier documentation shows that the carrier made reimbursement for the prescription medication, Colace SS on December 12, 2011.
3. Review of the submitted documentation finds that the carrier denied reimbursement to the injured employee for "medical/office notes required bill/HCF1500 bill from the medical provider-cannot process balance due after Medicare has paid portion". The injured employee submitted an invoice showing the injured employee made a payment of \$30.14 for the treatment provided on February 16, 2011 and March 24, 2011. Injured employees do not have access to the CMS-1500 billing format; this form is used by medical professionals not patients. Injured employees do not receive copies of the office notes; nor does 28 Texas Administrative Code §133.270 require the injured employee to submit office notes to the carrier.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$60.28.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$60.28 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

May 31, 2012
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.